

A.I.D. EVALUATION HIGHLIGHT NO. 9
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Evaluation of A.I.D.'s Family Planning Program in Kenya
(PN-ABG-005)

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Summary

Since the mid-1960s, the Agency for International Development (A.I.D.) has been a major donor in helping provide voluntary family planning services in developing countries. In 1990, the Center for Development Information and Evaluation initiated a six-country impact assessment of Agency investments in population and family planning programs.

Kenya was the first country to be studied in this series. It is one of the countries where A.I.D. has worked longest in population and family planning nearly a quarter of a century. Also, although population growth rates throughout the world were falling by the 1980s, Kenya's was not. Population growth there had peaked at 3.8 percent in 1979, and the total fertility rate (TFR) (the average number of births per woman) of 7.9 was the highest known in the world and the highest ever recorded for a population as large as Kenya's (estimated currently at 25.3 million).

Since then the trend has been reversed, in large part due to the political commitment of the Kenyan Government, combined with accelerated efforts by A.I.D. and other donors to expand the family planning program (Table 1).

A.I.D. has assisted Kenya in population and family planning since 1972. At first the support came through centrally funded cooperating agencies. Since 1983, a large A.I.D. bilateral program, totaling more than \$59 million, has also directly supported a broad range of family planning activities in Kenya. While working collaboratively with other donors, A.I.D.'s special focus has been on expanding family planning services and improving their quality.

Program Elements

Targeting certain program elements, A.I.D. support has made possible

- *Fertility surveys that drew attention to rapid population growth and monitored progress

- *Family planning training for health workers

- *Businesses adding family planning to health services for their

employees

*Introduction and wide acceptance of voluntary surgical contraception

*Better contraceptive logistics management

*Improved management of nongovernmental organizations

Impact

The nature and style of A.I.D.'s assistance have enhanced its impact. First, the presence of a strong technical staff in USAID/Kenya enabled A.I.D. to provide technical assistance of a type other donors could not provide. Second, A.I.D. was willing to take on the longer term, blue collar jobs of building a family planning program such as logistics, institutional development, and financial and information systems. Third, by using central as well as bilateral funding mechanisms, USAID/Kenya tailored technical assistance directly to local needs.

The ultimate goal of a family planning program is to lower the population growth rate. To achieve this, it seeks to lower the fertility rate and to increase the use of contraception. Kenya has now begun to succeed on all three counts:

*Kenya's population growth rate fell from a high of 3.8 percent per year in 1979 to about 3.6 percent in 1990.

*The fertility rate has dropped from about 8 children per woman in 1979 to about 6.5 in 1990.

*The use of contraception has almost quadrupled over the past decade. In 1978, just 7 percent of married couples of reproductive age used family planning. By 1989, the figure stood at 27 percent.

Increasing use of contraception, through the family planning program, has been the most important factor in the recent decline in fertility. Although Kenya's population growth is still high, a long-established trend has been reversed, marking a significant breakthrough.

Kenya's family planning program is also helping to improve the nation's health by reducing the incidence of high-risk pregnancies and births, factors that directly contribute to the illness and death of mothers and children. In Kenya, fertility rates in all high-risk groups declined sharply between 1977 and 1989. There can be little doubt that this has contributed to declines in infant and maternal mortality.

The impact of the family planning program reaches beyond demographics and health. Many Kenyan families directly experience the economic benefits of family planning: by having smaller families, they can afford to feed, clothe, shelter, and educate

all their children. For Kenya as a whole, cost-benefit analysis shows that investments in family planning are more than repaid by substantial savings in education, health, and other expenditures.

Background

Kenya traditionally has had one of the best performing economies in sub-Saharan Africa. During the first 17 years of independence (to 1980), its per capita output grew by about 3 percent each year. Then, in 1984, a devastating drought, on top of increasing scarcity of arable land, slowed agricultural growth. Kenya experienced an economic recovery during the late 1980s, with overall economic growth of about 5 percent per year. However, population growth undercut much of this progress.

Population growth also has exerted pressure on the land. At the time of independence, there was almost 1 hectare of arable land per person. Today the figure is one-half that, and, at current rates of population growth, there will be only three-tenths of a hectare per person by the year 2000.

Kenya's high fertility rate stems largely from patriarchal traditions that prescribed early marriage and encouraged continued childbearing throughout a woman's reproductive years. More recently, traditional values and behavior have changed. Now only a quarter of Kenyan women live in polygynous unions, and the duration of breastfeeding and postpartum sexual abstinence traditional child-spacing practices has decreased, although the primary role for most women is still that of wife and mother, and motherhood remains the most secure source of social and economic status.

Although traditional values and practices blocked early efforts to establish family planning in Kenya, they are now giving way to "modern" values and economic realities. In particular, the changing status of women has made them more open to family planning.

Almost immediately after independence in 1963, some political leaders began expressing concern over negative impacts of rapid population growth. In November 1967, the Government announced that it was establishing a national family planning program, the first in sub-Saharan Africa. For at least the next decade, however, the program was not a high priority.

During the mid-1970s other donors, including the World Bank and the United Nations Population Fund, joined A.I.D. in a more concerted effort to get the family planning program going. A fairly effective infrastructure for providing maternal and child health (MCH) services had been established and was strengthened. Only a portion of the MCH workers were also trained in family planning, however. Thus access to contraceptive services remained poor, especially outside the major cities. As a result, family planning use was low and dropout rates high. The Government and donors had established a goal of reducing the annual rate of population growth from 3.3 percent in 1975 to 3.0 percent in

1979. Instead, the 1979 census revealed an increase to almost 4 percent.

A.I.D. Assistance

The Kenyan Government and Kenyan nongovernmental organizations (NGOs) share credit for marshaling the human, financial, and political resources needed for the national family planning program. Donors other than A.I.D. have also made important contributions. A.I.D. assistance has focused on specific improvements needed to meet the growing demand for family planning services.

A.I.D. began helping with family planning in Kenya in 1972, but it contributed fairly small sums of money and had little on-the-ground presence until the early 1980s. Although A.I.D. appears to have played a "seeding role" during this period, early projects were not very successful, due, perhaps in part, to the then-rudimentary government infrastructure and the lack of serious interest in family planning throughout Kenya.

Since 1983, however, the picture has changed dramatically. USAID/Kenya now has a staff of eight professionals, Americans and Kenyans, assigned to family planning. It assists the Kenyan family planning program through four bilateral population projects totaling \$59.2 million, supplemented by centrally funded projects (Table 2). Although A.I.D. has supported a wide variety of population activities in Kenya, it has concentrated on the following eight areas:

- *Information for policymakers
- *Community-based family planning
- *Training for health workers
- *Contraceptive logistics and management
- *Voluntary surgical contraception
- *Nongovernmental organizations
- *Role of the private sector
- *Council for Population and Development

Findings

Use of contraception in Kenya increased substantially between 1977 and 1989 (Figure 1). Between 1977 and 1978, only 7 percent of Kenyan married women ages 15-49 used contraception; by 1989, 27 percent did. Modern contraceptive methods accounted for the largest part of the increase. The greatest gains occurred in the use of oral contraceptives, tubal ligation, IUDs, and injectables. These four methods are almost equally popular,

indicating that each serves the needs of a separate group of contraceptive users.

By 1989, periodic abstinence was by far the most widespread of the traditional methods. Practiced by 7.5 percent of Kenyan couples, abstinence was the single most popular method of family planning overall. However, its efficacy is questionable because only about one-third of the Kenyan women who have ever used this method can correctly identify the fertile period.

The family planning program succeeded in informing women about where to obtain contraceptive supplies and devices. In 1977-1978, about 70 percent of Kenyan women knew where they could go for family planning. By 1989, 91 percent had this information.

As to where Kenyans actually receive help, a 1989 survey found that about 70 percent of modern-method users obtained services from Ministry of Health facilities, and the remaining 30 percent were served by the private sector. These figures may overstate the importance of the Government sector, however, because many Kenyans using nongovernment clinics mistakenly think they are part of the Government network.

The average woman in Kenya is better educated than her mother and has greater opportunity to make decisions independent of family and relatives. Fully 95 percent of Kenyan girls ages 15-19 have had some formal education, compared with only 35 percent of women ages 45-49. As everywhere, increased female education is correlated with lower fertility levels. Today, Kenyan women with no formal education have an average of 7.2 children; in contrast, women with 12 or more years of schooling average fewer than 5 children. Also, fewer women now work on communal or clan lands, and more women hold jobs with cash earnings that they control even if earnings are meager.

The demand for family planning is high and has been rising rapidly in Kenya. About 75 percent of married women in 1989 said they wanted either to limit or to space future births. Increasing numbers of women, at ever earlier ages, are deciding to limit family size, a concept once considered alien to Africa (see Figure 2). Since 1977-1978, the percentage of married women wanting no more children has nearly tripled, from 17 to 49 percent. Perhaps more striking is the fact that 11 percent of married women said they had not wanted their last child. An additional 42 percent said they had not wanted their last child so soon.

For the average Kenyan family, it is the rising cost of education that makes them feel directly the economic costs of high fertility. In fact, the cost of education has probably been the single most important factor contributing to increased demand for family planning in Kenya.

For the first time in its history, Kenya's fertility has fallen significantly. In 1977-1978, TFR was about 8 children; estimates for 1990 indicate a TFR of 6.7.

With respect to health impact, it is well known that children born to women who are too young or too old, who space their births too closely, or who have more than four children are more likely to be ill or to die at birth or in infancy. In Kenya, fertility rates in all four high-risk groups declined sharply between 1977 and 1989. There can be little doubt that this decline has been partly responsible for the continuing decrease in infant mortality rates.

To illustrate the relative costs and benefits of family planning in Kenya, the study compared the impact on TFR and contraceptive use of three different scenarios on Kenya's future. Costs of the family planning program were compared with benefits resulting from savings in Government spending on education and health care for births averted. Not included were other possible costs and benefits that might result from the program. In these scenarios, the cumulative savings on education and health expenditures far outweigh the costs of family planning, supporting the position that family planning expenditures in Kenya can be justified not only on social and humanitarian grounds but on economic grounds as well.

With regard to sustainability, A.I.D.-sponsored family planning projects have made institutional sustainability a high priority. These projects are fostering Kenyans' technical and administrative capabilities so that Kenyans can eventually take full responsibility for the family planning program (see Table 3). The financial prospects are less favorable; on its own the Government will not be able to pay for family planning services in the foreseeable future.

USAID/Kenya has helped shift some costs to the private sector and contraceptive acceptors, encouraging user fees where possible, although what clients can pay is only a fraction of actual costs.

Conclusions

The evaluation team reached a number of conclusions concerning what factors were most important in explaining the family planning program's performance.

About A.I.D. Assistance

1. The nature and style of A.I.D.'s assistance was crucial for the expansion and institutional strengthening of Kenya's family planning program. Among A.I.D.'s strengths were the following:

*The presence of a strong technical staff. Although a technically strong in-country staff has now been accepted as one of A.I.D.'s inherent strengths as a donor in all sectors, it is especially important during the development stages of complex population assistance programs.

*Hands-on problem-solving. A.I.D.'s hands-on approach has been an important factor in its ability to establish close professional

working relations with both the public and private sectors. A.I.D. has been willing to take on what might be called the blue collar jobs of building a family planning program such as logistics, institutional development, and financial and information systems.

*The combination of central and bilateral funding mechanisms. The use of both central and bilateral resources has made it possible for A.I.D. to capitalize on its strengths as a donor. The Mission's use of buy-ins to central projects was extremely important in providing technical assistance for the program, and it ensured that these activities were consistent with and directly supportive of the Mission's strategic objectives. Sole reliance on one funding source or another would have limited the Mission's options to respond to opportunities. This was especially the case in expanding private-sector initiatives, since governments are often reluctant to use scarce bilateral funds for these purposes.

*Matching assistance with clear comparative advantage. A.I.D.'s focus on service delivery matched the most critical unmet need in Kenya and engaged A.I.D. where it has a clear comparative advantage. Other donors are simply not prepared to provide high-quality technical assistance to support service-delivery programs.

2. An appropriate combination of interventions in both the public and private sectors is essential in establishing family planning accessibility and program sustainability. Few national family planning programs rely on any one sector to deliver services. Although Kenya has a strong government-financed rural public health system, it alone cannot reach everyone seeking family planning services. At the same time, Kenya's NGOs and private, for-profit sector cannot on their own provide complete coverage. Thus donors such as A.I.D. should not rely on interventions with a single focus. Multiple approaches also help minimize the impact of the inevitable setbacks and delays during the early days of program development.

3. Experts' views are not always a reliable guide. Because voluntary surgical contraception came late to many countries in Latin America and Asia, experts argued that Africa was not yet ready for it. They contended that African couples would be interested in family planning only for child spacing, not for limiting family size. A.I.D. nevertheless decided to try the method in Kenya. The public response revealed a substantial demand, and Kenya is now playing a lead role in introducing this method to other African countries.

4. Periodic, high-quality surveys are a valuable tool for guiding population policies and programs. In Kenya, three fertility surveys financed by A.I.D. were instrumental in calling policymakers' attention to the urgency of the population problem. Those surveys also monitored the progress of the program. The most recent results, which found that the increase in the population growth rate had finally been reversed, have encouraged

Kenyans to redouble their efforts.

About National Family Planning Programs

1. An official family planning policy without strong political backing is not enough. This is especially true when a program is just beginning and trying to overcome bureaucratic inertia and opposition as well as pronatalist cultural beliefs and practices. The Kenyan family planning program began to make progress only when the nation's president publicly and consistently endorsed the program's aims and made family planning a national priority.
2. The collaborative relationship between the Government of Kenya and the private sector is a model for other sub-Saharan African countries. Collaboration between the Government and the private sector is crucial to expanding the availability of family planning services. The Kenyan model of cooperation, involving both NGOs and for-profit firms, serves the program well. It has expanded resources and increased the geographic and demographic reach of family planning services.
3. Female service providers encourage the use of family planning. Since women are the chief users of family planning, it is important to be able to relate to and address their concerns. In Kenya, the workers providing family planning counseling and services are chiefly women, with the result that mothers are more willing to ask about, adopt, and continue to use family planning.
4. African culture does not pose a permanent obstacle to modern family planning. The Kenyan experience shows that nothing inherent in African culture makes it forever resistant to modern family planning. As in other regions of the world, modern values and economic pressures are replacing traditional values and behavior. Thus, although African cultures traditionally have been pronatalist, they can and do change. In Kenya, for example, women are now using modern contraception not just to space their children but to limit the size of their families.

This A.I.D. Evaluation Highlights was prepared by Robert Schmeding of the Center for Development Information and Evaluation (CDIE). The Highlights summarizes the findings of a field evaluation of the A.I.D. family planning program in Kenya carried out by CDIE in October 1990. The evaluation of the Kenya program is one in a series of six CDIE case studies of family planning in developing countries. Other countries in the series are Ghana, Honduras, Pakistan, the Philippines, and Tunisia. Evaluation of A.I.D. Family Planning Programs: Kenya Case Study, A.I.D. Technical Report No. 3 (PN-AAX-257), is available from: A.I.D. Development Information Services Clearinghouse, 1611 North Kent Street, Suite 200, Arlington, VA 22209-2111, Telephone: (703) 351-4006